Meg: Welcome back moms and dads. It is such a pleasure to have you here with us today. As usual, each week you are joining me, Meg Faure on Sense by Meg Faure, where we talk about the different things that moms and dads come [00:01:00] across in the first few years of their children's lives. And we touch on a wide variety of subjects from infant feeding through to development stimulation, health, And today we are touching on a subject that is actually very close to my heart. And that is the subject of cesarean sections. Some of you may know that my third one was an emergency cesarean section. So I am right there alongside all of you moms who have either chosen the route to deliver your little one through cesarean section or are going to have to, for a reason that is outside of your control, or maybe you're looking back and you've just had your baby.

Meg: And you had a cesarean section. And today we're going to be talking about all types of things surrounding this specific topic. And of course in this particular case, I'm certainly not an expert other than having had a cesarean section. And so I am accompanied by somebody who is very close to woman and their birth.

Meg: And that is our specialist midwife who is on the team with us. And her name is Tina Otte. Tina, thank you so much for joining us today.

Tina: It's such a pleasure.

Meg: Always [00:02:00] wonderful to chat with you. So Tina and I have worked together over many years. She is an incredible source of wisdom for moms around the birth of their child. She runs very, very busy antenatal classes, and if you haven't done her preparing for birth class, which is inside the parent sense app, you really should go and do that.

Meg: Tina, you, other than doing antenatal classes, what else has it formed part of your career as you've moved along as a midwife?

Tina: Gosh well, my first child got me into teaching antenatal classes because I got the shock of my life. And along the way, I was always very active at school and did exercises. And with my medical knowledge and my aerobics knowledge, because I taught aerobics for a while, I went on to develop a course for fitness instructors and midwives on safe exercise in pregnancy which was a huge help for me for the longest, longest time. And then in the year 2000. I've been qualified as a certified baby massage instructor and I've been doing baby massage [00:03:00] instructing, if you like, for, for 23 years almost. And along the way, I got internationally certified, I realized that as a midwife, you can't

just walk off a labor ward or a maternity ward and just know how to go and teach and that.

Tina: So I had to do a lot of research. I've written a couple of books and of course my greatest teachers have been my own children and the people that I've had the privilege of sharing their journey through pregnancy, birth and early parenthood. Learned a lot from them as well. A lot.

Meg: an absolutely amazing journey. Absolutely. And you've had an amazing journey, Tina, and touched so many lives. So today we're going to be talking not about vaginal delivery, which is what you do teach quite a bit of in your antenatal class. But we are also going to talk about, or we're rather gonna talk about cesarean sections.

Meg: And the reason that we chose this topic is that recently we did a Preparing for Parenthood event with you. And there were so many questions from women who are going to be having caesars. And so we decided to bring those questions here today. For those of you who are listening from abroad, outside of South Africa.

Meg: [00:04:00] You might want to know that South Africa has actually one of the highest cesarean section rates in the world in the private sector. I think it sits at around about 75 percent in some years of babies are delivered by cesarean section. And so it's becoming an increasingly popular choice in many countries and including, of course, South Africa.

Meg: Now, the reasons for choosing a C-section vary from one woman to the next, and sometimes it's driven by safety and reducing the risks associated with vaginal birth. And that's especially the case now that women are often having babies later on the case of a prem birth or obviously are multiple births as well.

Meg: But in other times, women actually just choose C-sections because they just want predictability. They just want to know exactly when their baby is going to be born and they don't want to leave it up to mother nature because they like to have some sense of what's going to happen and maybe there's very heightened anxiety with just leaving it to kind of run its course.

Meg: So today we are going to be talking about the very best tips that you can do in order to prepare yourself. Both for the cesarean delivery, but also how to speed [00:05:00] up recovery and also how to connect with your little one immediately after birth. So we're going to be covering off a whole lot of

information all the way through from preparing your head, preparing your body, what happens in the moment, and then of course, what happens afterwards.

Meg: And Tina is going to be our guide. So Tina, I've got some wonderful questions from our listeners and we're going to dive right in.

Tina: Fantastic.

Meg: So, cesarean sections are on the increase and certainly in South Africa we have a very high rate of C sections but it might be useful for us to understand why it is that C sections are so often recommended, and are there specific medical indications when you really should be having a C section?

Tina: Okay. So let me answer the first part of that question. First and certainly pertaining to South Africa and the state of our health system and the state of our nursing and the qualifications and there are many doctors who love doing vaginal births But in terms of pre birth care, post birth care, labor care, and that they don't always have confidence in the staff.

Tina: And if a mom hasn't delivered at a certain time in the day, might say, listen, [00:06:00] if, by five o'clock we need to make a call. And a lot of them are then encouraged. Reaching the moms to for very good reasons and in terms of safety and times coming out at night, whatever, in our country, that situation.

Tina: There's also a huge issue with litigation as well. And as our doctors are Probably pay some of the highest insurance, medical malpractice insurance in the world. So that's a huge consideration as well. If we're looking at the second part of the question as to why medical reasons for caesarean, I kind of put it into three categories that would fall under maternal, it would fall under fetal and it would fall under mechanical. So for example, maternal would be a mom with diabetes, you know, they burn energy, their babies are big, they can go into comas. So, they could possibly go for vaginal birth, depending how well controlled they are.

Tina: But very often the babies need to come sooner cause they're bigger and doctors just would not, you know, nobody likes to deal with an emergency. We don't ever want to go there. So they'd [00:07:00] rather be cautious. And in terms of that if a mom has a heart problem, heart disease or something like that, if she has preeclampsia or HELLP syndrome, of course that's without, any arguments it would be safer for a mom to have a seizure.

Tina: It's more control. We have all the necessary experts on hand. Should something actually go wrong?

Meg: Tina, just, just before you move on, just, you mentioned the word HELLP syndrome and that people probably don't know what that is. I know that one of the symptoms is very high blood pressure, but what is it?

Tina: Okay, so it's to do with your platelets. It's a very long name. And I can't always remember it myself. It's like a next progression onto preeclampsia. It's very dangerous. And the thing, about it is that moms don't always realize with the preeclampsia being going on to where there's elevated platelets and there's all kinds of problems in the mother's blood that mothers don't feel as sick as they are.

Tina: And they can go downhill really quickly and we can lose a mom really, really quickly. And that's why they always check your blood pressure [00:08:00] and they're checking you what's in your urine and molecules that shouldn't be coming in the urine, they are on the urine and they're checking your blood.

Tina: Things like the headaches and all of those things are warning signs. And that's one of the top, top reasons for in my estimation anyway, for a really good reason for a mom to be having Caesar for a medical kind of thing, because that, that can turn ugly really, really quickly.

Meg: Okay. So we've got our first bucket, which is all of our mom reasons, our mom driven reasons.

Tina: Correct. So then the next is looking at our fetus. So it's a little baby. Okay. There might be a little baby. That's just not growing a small for gestational age intrauterine growth retardation for whatever reason that doctors may decide that baby is better out in the world than inside the womb. It's a big decision to make.

Tina: It's not made lightly. And then those babies would be taken out in a control situation with the pediatricians and everybody on hand to take that baby to wherever that baby needs to go in order to be okay. Multiple pregnancies and many parts of the world, [00:09:00] twins are delivered vaginally, but in our country, it's don't even ask unless you go to a midwife, you won't easily find a obstetrician being very keen to deliver twins vaginally at all. Prematurity, as I said, a male presentations that could be a baby could be transverse, or a baby

might even be occipital posterior. And a mom in that case would be, that's when the baby's back lies against the mother's back.

Tina: So the, the diameters aren't all right for that baby to come through, but there's a lot you can try and do beforehand if you are keen to have a vaginal birth, but this baby's persistently, sitting with its back against your back. And the things you can do, there's certain exercises you can do, positions you can get into, a visit to your chiropractor, looking at your pelvis, to try and get that baby into a better position.

Meg: My second was born like that and oh my word was that sore. That was a vaginal delivery with a lot of pain.

Tina: Oh yeah, that's it. I did not know that. I'll take my hat off to you. It's usually prolonged and the pain is not fun at all. But you know, once again, [00:10:00] there's certain things you can do with reflexology and you're going to a qualified practitioner who can help get that baby into a better position.

Tina: And what I used to do in my exercise classes used to get mothers to actually crawl because we don't crawl anymore. So we can get the heaviest part of that baby, the back to kind of turned into mom's front, so I would encourage the moms to like lean on their coffee tables on their knees. Crawl down the passage.

Tina: And of course, the father's had a fun time with that. And it's like, make her work up and down and polish floors. But that's one seriously, one of the best things that you could actually do to turn an OP baby. And it's not a huge male position, but it's one that can really make you uncomfortable. You go through labor and end up with a Caesar anyway.

Meg: so you can actually deliver those babies naturally and in many countries, you certainly would be delivering them naturally. What about breech babies, babies who coming with their feet first?

Tina: Yes. Okay. So in this country, there's not even a chance you find an obstetrician to deliver a breech baby because it's, it's high risk and you need to be well [00:11:00] experienced in doing that. And, with all respect to the doctors that if you haven't done it for a while, if you haven't done many, then you don't want to do many because we're not in a country where you have to do that or you need, that's an option you have to try first to try and deliver that baby.

Tina: But they won't because of the high risk and the litigation issues and that I know some doctors who said, if you persist in me wanting a vaginal birth with a breach, for example either find another doctor or sign this document and say that you will not hold me responsible. So there's, there is the litigation and the legal side of things that really always kind of mess up things a little bit for us.

Tina: But there are many midwives who are very proficient at doing vaginal breech deliveries. And once again, depending on the position of that baby and that sometimes you can get the baby to turn but in a splint position, those babies often don't turn. But if they got their little knees curled up or, or sometimes feet first, then sometimes we can try, but that's certainly one of the top reasons up there for cesarean.

Tina: So when [00:12:00] we're looking mechanically at the uterus, if you like. Okay, so sometimes, we, in labor, failure to progress would end up with Caesar very often. But what we could look at is, would be things like placenta previa. There's no way that baby would be alive, okay, if it came out.

Tina: So there's no question, it's like, thank goodness there's another way out,

Meg: the word placenta previa means?

Tina: Okay. Previa being previous in front of the baby. What happens is the placenta and the degrees of it, but if it's very close or covering part of cervix or completely covering the cervix that cushion of the placenta. As the cervix starts to open, it would then start having a problem with the blood supply to the baby, which means there's no oxygen to the baby. So there's no way to get that baby out other than to Caesar that mommy. So that's an absolute reason. And that's also what I'd like to say.

Tina: You get absolute reasons where. There's absolutely no way out, and that's one of them, okay, for that baby. And then you get relative [00:13:00] reasons where, like, an OP position, as there's a chance we can get that baby out, but we'd rather not put you through that kind of thing. And like you just said, with an OP, you did it, and that's, it's unbelievable that you did.

Tina: And It's longer, usually it's more painful, whatever. And the doctors would be like, I mean, because the whole thing of the doctors have your interests at heart at the same time, looking after their own responsibility to you and what they think is best for you at that time. So just getting back to the placenta being in the way of the baby, that's an absolute reason. And if a mom has had prolonged. rupture of membranes or prolonged water release. Okay,

then we wait 24 hours maximum and then they're going to Caesar. Sometimes we wait for labor to start and if it hasn't started or it started and it's not doing very well they might just induce or augment your labor, but very often once 24 hours is up and sometimes even before there's no labor Waters have been [00:14:00] broken for a while They're going to Caesar you and then maybe would be put onto

Meg: was,

Tina: and you know that kind of thing

Meg: and that was my baby number three. So my baby number three, my waters broke on the Friday night and I was progressing quite nicely until about one o'clock on the Saturday afternoon. And then my labor just stopped at eight centimeters, went no further. And eventually the following night on the Saturday night, they said, look, it's been 24 hours.

Meg: You're going nowhere. So we had a Caesar. So I suppose an emergency Caesarean in that I wasn't, I mean, it wasn't too swift. We were able to take our time because it was no massive emergency, but there was no planning for it.

Tina: So that's also Another thing that I'd like to also clear up is that you had a non urgent Caesar, but one that you needed, and then you can have the urgent Caesar, which is when we run, and we've got, minutes, and you might even need to have a general anesthetic because we haven't got time for an epidural spinal to, to take hold, and do you know what I mean?

Tina: So you had an unexpected non urgent Caesar but still, I'm sure you had to deal with that because you'd had two [00:15:00] vaginal births, and you must have been not, what the hell.

Meg: It wasn't on the plans. Yeah, it definitely wasn't on the plans. Yeah.

Tina: Yeah, no, that's that's a hard one.

Meg: I mean, you, you've just touched on something there, the anesthesia. So I had a spinal block and I had not had pain relief with my other two. So I didn't have an epidural. So that was new to me, the whole bending over and then finding the little space between your your spine.

Meg: Could you talk us through the different types of anesthetic that can be used with caesarean sections?

Tina: So there are the three types. Okay, there's the spinal, there's the epidural, and then there's the general anesthetic, which is something we avoid unless a mom really doesn't, for whatever reason, doesn't want to be awake. Or there's an emergency and there's no time to sit with a needle in the back and keep her still and the whole thing.

Tina: Most of the doctors, certainly in this country, prefer spinals. They happen, they take effect very quickly. They wear off of three to four hours post surgery. And there's no strapping and there's no needles or pipes in your back. It's, they put it in. Once it's in, it's in. Three to four minutes to take full effect and there are other doctors who prefer to do the epidural.

Tina: It takes a little longer to take effect. And they give you a little bit more of the medication. And that also [00:17:00] can wear off over time and you can also control it from the outside of the spinal. It's in, it's in the plasters on your back and off we go. Then there's some doctors who do, and it's not very common in the country combination. So, and especially for afterwards that your spinal will wear off quite quickly, but your, the epidural may maintain your pain a little bit slower, your feeling comes back a little bit slower, it starts with a bit of pins and needles and what most moms don't realize is that as you start to feel more as your anesthesia is wearing off, you actually get your feeling back from top to bottom and I don't mean top to bottom here, I mean top belly and to bum.

Tina: So you start up here at the belly and then slowly you get more and more feeling and until you. Kind of in your, in your buttock area.

Meg: Okay.

Tina: very important that different doctors do different things and they also operate differently and they sew you up differently. Some doctors use [00:18:00] glue, some use staples, some use stitches and usually the two doctors you have one.

Tina: And working on one the other side and sometimes they do single stitches, sometimes they do one long stitch, sometimes you might find you touch on the one side than the other because of the different people, doctors working on you. So they're different. The glue bit really fascinates me.

Tina: Now, I've never had a Caesar so I don't know what that's like at all, but I've just heard, With feel afterwards and I'm sure you can relate to that as well. As to what does it feel like when someone is actually working on you and beside you and one mom

Meg: very

Tina: feels like someone's ravaging in a drawer.

Meg: Yeah. Yeah. You don't feel pain. You just feel pressure. You can feel it. Something's happening. Other things

Tina: what I'm told. Yeah,

Meg: So, I mean, other things that moms probably want to know is that usually there is a green sheet between them and, or sterile sheet between them and the Caesars, so they can't see what's going on.

Meg: And that's fairly typical, isn't it? Yeah.

Tina: it's fairly typical. So, one of the things [00:19:00] that we discussed a little bit earlier was just how do you prepare yourself psychologically, emotionally, and if you've made the decision already for whatever your reasons are, sometimes there's a medical reason and you have to come to terms with it.

Tina: terms with that, especially if you were hoping for a vaginal birth and you got to talk it through and whether it's with an educator, your partner, your doctor, it's just to express your feelings and maybe your disappointment on that. If we are looking at just preparing again in my classes, I like to tell the moms, like, what are you going to expect?

Tina: What's going to happen in theater? Especially if you have a lot of people associated, hospitals with bad things and sickness and death and, this is over the years people have shared this with me. So what's going to happen in theater, what is going to feel like in theater and also once again is the first stage when we preview there's a second stage when you're going to have your baby and there's a third stage where the placenta comes out and there's the fourth stage the golden hour when you're in the post op room.

Meg: So let's, so let's just talk about, so let's just talk about each of those stages. [00:20:00] So, I mean, first of all, do cesarean sections always happen in a theater, in an operating

Tina: well, they should always have

Meg: always happen in operating theater

Tina: It's sterile in an operating theater, you'll be taken in where they check you, they check your allergies, they check your your name, they make sure your baby's name, just like with a normal anesthetist might come and chat to you and he'll explain to you how many people are going to be in the room. That's a surprise for a lot of people. It can be up to 10 people in the room. In your birth plan, you might ask for them to play some of your music. You might want to use some aromatherapy if you're very nervous, whether you've chosen this or not, it's major abdominal surgery and there's, it's clinical and, So sometimes you might want something to just calm you down, whatever, so they're going to check what's very important to realize is that only the mom can sign for permission for Caesar, epidural, spinal, whatever her partner can't.

Tina: And that's an important thing to remember as well before you get your medication. you [00:21:00] get your pre med, your medication to sort of keep you calm and dry your mouth a little bit, whatever. Once you've received that, you can't legally sign anything because you could, you say you didn't remember signing anything.

Tina: So that the timing of that's also very important. You'll then be taken into theatre. You'll be prepped. Usually your one arm is out on the side where that's the arm they're going to give you your drugs in. Your anesthetist is standing or sitting very close to you at the head of the bed. He can be a great source of help in terms of taking photographs.

Tina: They, in this country, they've stopped the filming because of the litigation. So they, you're not allowed to film in theater. They're also going to tell the dad where they can sit if they're feeling woozy, if they, where they can fall, joking. Okay. But if they're feeling See, like say if you're feeling funny, go and sit in the corner over there.

Tina: So they talk it through all the way so that the dad doesn't have to be the one taking the photographs. It's his birth too, so that he can [00:22:00] watch it not only through a lens, but that he can be very involved. So the anesthetist great in terms of helping you and telling you what. going on. If you lie down when you're pregnant and you're kind of in your nine months of pregnancy, you can't even see your pubic hair at that time.

Tina: And that's where they're going to cut you. So you're not actually unless, and be aware of this, the goggles that the doctors wear and the lights, then often. You can see the reflection and that is traumatized mom. So that might be forget the screen. I mean, the screen might be there and you still might see that.

Tina: So don't look up

Meg: Okay. Interesting.

Tina: know, try and remember that. I've just had some moms who said, I did not saw some things I didn't want to see and I couldn't see it lying down. But as soon as I looked up, I

Meg: It was there. Yeah. And Tina,

Tina: Just Yeah,

Meg: and Tina, so now you've been wheeled in, you've been prepped, you've done your signing away, you've now been cut, but from the time of the cutting, let's say from the time you're lying there until your baby comes into the world, what sort of period of time are we looking at?

Meg: Is this 10 minutes? Half hour?

Tina: So from start to cut. [00:23:00] Okay, to the birth of that baby when because they go through all the layers and if they're not an emergency, an emergency three minutes, that baby can be out normally by seven to 10 minutes, usually the whole thing, 60 to 90 minutes, depending on whether it was an emergency or whatever. In a planned cesarean, then that's when it's usually about an hour or so.

Meg: Wow. Okay. So hold on. So let's, let's talk this through. You've gone in, your baby's been born within 10 minutes, and now you've got another hour to go inside this theater. So what is happening? Where is your baby? What can you expect at that point?

Tina: So if you leaning more and more to having a gentle Caesar or a skin on skin Caesar. And this is something I've certainly fought for, for a very long time, especially moms who are choosing to have the Caesar for personal reasons and there are many good personal reasons as well.

Tina: But they don't want to miss out on having that baby straight away. It's not allowed in many [00:24:00] hospitals in South Africa. But we're working hard on that as we just trying to educate staff on the benefits of skin to skin and that baby. Going to mommy for both of them as soon as possible, because if she's had a booked Caesar and she's had no labor at all like in your case, you'd had some labor, your oxytocin levels were working beautifully, your endorphins

were working for you, and they were still in your system and you had your, your So you and your baby would have got the benefits of that and your baby would have gotten lots of the benefits of labor that labor brings.

Tina: So never ever kind of feel like I ended up with a Caesar, I did it for nothing because never ever have you done it for nothing, especially if you've had a labor terminated by caesarean. But if you are having your Caesar, this is something you'd have to discuss with your obstetrician and him with the pediatrician.

Tina: Okay, as well, because the pediatrician is there in theater as well and he's waiting for that baby. So it's that whole thing of time. Okay, and he's got clients that he needs to get back to in his rooms to [00:25:00] see parents and that, so it's not as, you'll have your skin on skin possibly, but it would be less time, but you've got to set up for it, got to be prepared for it, you can't just ask them, as they're wheeling you in, it's something you would have needed to discuss before.

Tina: So

Meg: just how, so just how natural can this process be? So, I mean, in a vaginal delivery, we don't like to clamp the cord too soon. The baby can still be attached to the cord when they're placed on their mom's chest. And then the mom can actually birthing the placenta while the baby's on her chest.

Meg: Talk to me about how much of that is possible with a cesarean section and how much of it is not an option,

Tina: Okay, so delayed cord clamping is a huge, huge benefit and more and more of the doctors are realizing it and they're doing it and it can be done in caesarean as well. So it probably would be considered delayed up to 60 seconds is fantastic because I said that the baby's blood is outside of its body when it's born.

Tina: So we just need that flashback. [00:26:00] They can wait 30 seconds and they can then, because the cord can usually reach up, that they

Meg: but is the baby now on your chest at that time or

Tina: So at this time, they're going to wait probably a little bit, 30 seconds, which just goes very quickly. And then they would show the baby to mother,

they clamp, cut the cord, and then it would be given to the midwife or the pediatrician, usually the midwife to exit.

Tina: And then they would take to the mom and this is where you need preparation. Maybe there would be that area. So if her one hand would be free, the other hand, she'd only have one hand that she can use the other hands, out with her drips and that in and we warm that area. Now, remember during labor, the oxytocin warms up her mother's body so that she can actually, she's much warmer up to two degrees warmer when we put that baby on the chest, so we keep our baby warm.

Tina: What hospitals around me is they blow some warm air onto the mother's chest and onto that baby, and then that baby and that mom and partner can then meet and greet that baby without having [00:27:00] necessarily, the APCOC can be done there, the very first test that your baby has on your baby's state at birth, one minute, five minutes, 10 minutes, and that one minute APCOC can easily be done here.

Tina: It's the matter of changing the thought process, and that baby's getting all the benefits of skin on skin. The most important one, and I really want to mention this, because these are when people say to me, Tina, I never knew that, I would have made a different decision had I known, when baby comes to the vagina, there's the micro biome, there's this whole thing of that immunity, seeding that baby's immunity.

Tina: Now, if the baby hasn't had any access to it. Any of the outside microbes, the good stuff, then we want to get that baby skin on skin because we have a lot of microbes here and we want to get that baby to breastfeed. So although we're missing out on the microbes of the, especially the lactobacillus and especially of the rectal microbes, okay, babies could still, like in your case, your babies would have got your vaginal microbes and that because your waters have broken.

Tina: And it was that invading. [00:28:00] But if not coming right through the passage, we are not picking up the, the sort of the rectal or faecal microbes we want to get that baby skin on skin there. And that's the hugest benefit of all. So touching that baby, smelling that baby getting mommy's hormones going because she hasn't had the buildup of hormones, which is why she might.

Tina: We'll struggle a little bit with the breastfeeding after Caesar. It just takes a little while for her body just to adjust and to I've had the baby so let's get the oxytocin going. Let's get the baby on the breast as soon as possible.

Meg: So to summarize what you've said there is that the baby will come out, they will do about a 30 to 60 second delayed cord clamping so that the baby can get all their lovely stem cells. The baby will be passed to the midwife. We'll pass it to the mom, lay it on her chest. And the important thing there is that the baby's skin to skin and breastfeeding as soon as possible. So babies do not need to in this circumstance, leave and go into a neonatal ICU or into a warm incubator to be warmed up because the mom's chest can do it adequately if you've [00:29:00] set it up in the right way.

Tina: So if there's been no emergency, there's no need to rush that baby out of theater. In fact, the longer that baby can stay with the mom, the better. But it's colder. Remember, it is colder, and that's one thing babies can't do. They can't warm themselves up. So once they've been with mom, whatever, she's getting stitched up, she's sorted out, there could be the time with dad as well.

Tina: But the pediatrician is waiting. You've had your five, maybe ten minutes. With baby skin on skin, PD is going to take, do a quick check on your baby and then give your baby back to the partner. Usually you're not likely to have half an hour or so there's too much going on around there.

Tina: So we make up for that time afterwards, , and I think everybody's had a baby and you and I specifically know how important those early moments are and it's something you can never get back. So if you're going to lose it, then it better be for a really, really good reason. And so, you know what I mean?

Tina: And that would be if your baby wasn't breathing, if you were bleeding out, [00:30:00] they would need to then rush the baby to, to neonate

Meg: Very

Tina: and you would not argue.

Meg: Very interesting. Okay. So we've had our babies. The next question and probably the last question that we're going to have time for today is how long do we stay in the hospital after our little ones are born by caesarean section and how do we manage pain? So what, what happens afterwards?

Tina: Okay, so your stay in hospital is usually Two to three days probably more three to four mostly moms are going home on day three depending on the situation But usually by day three you're going home What's important while you're in hospital is to learn as much as you can because remember you're not only postpartum Going home to a 24 7 job, you've had major abdominal surgery

and on the level of hysterectomy and you wouldn't, you're not allowed to drive for three weeks, maybe as long as six you're going to need help at home with lifting.

Tina: You are going to have some limitations and [00:31:00] you've got a wound that you've got to think about. You'll have pain, but in a different place. from where a vaginal birth mom would have it kind of in her vaginal area your pain is going to be your upper ribs, here, the trapped air you might have bladder issues or getting your urine going again you, with Caesar very often one of the things they want to know is how you know, have you have you passed a stool?

Tina: But have you passed urine so that we can see there's gonna be no damage to the bladder So full bladder can it can be a problem, constipation can be a problem and then you've got a wound But you've got to look after and you've got to make sure that it doesn't get infected. There's no bathing for the first four weeks or so And then your dressings are for different doctors, showering is all good.

Tina: And the way they put dressings and that on you, they are amazing. These days, not when I did my nursing, it was very different. And we've come a long way since then. What I really want to say is the pain relief as your pain starts coming back. And you're feeling the pins and needles.

Tina: You [00:32:00] might think, oh, no, I'll be fine. And then the full onslaught of the fact that you've just had a major operation is going to hit you. You normally get an opioid of some kind and an anti inflammatory. Be sure to take it. If it's prescribed for six hourly. Make sure you're getting it six hourly. In fact, if they haven't come to you after about five hours, start reminding people because it takes a while to find the sister who's got the drug covered keys and then to draw up the drug and then someone goes on lunch and then they forget to give it to you.

Tina: So make sure, rather keep your, your pain relief consistent, even when you're feeling okay, because you're taking it. Then to feel anything kept screaming pain and then try and get rid of it again. So be sure to follow your doctor's instructions. Take your pain medication. You can still breastfeed. You're going to have to watch with your positioning. Your milk might take a little bit longer to come in, but it will come in. Just get help, [00:33:00] eat well, sleep as much as you can. Anything you would do. Going home with a new baby. I know that sounds ridiculous.

Tina: Sleep as much as you can, but sleep when the baby sleeps. Move, move, move, move. When you get up and make sure that there's always someone around in case you faint or don't ever lock the bathroom door in hospital that we can't get to you. Do you know those little, those things, but get help, because especially with lifting and even beforehand, cook up your meals.

Tina: It's just with surgery. It's just another layer of things to consider.

Meg: Very interesting. Well, it really has been a fascinating chat, Tina. And I think you, we've kind of delved into stuff that yes retrospectively it's all stuff I know because I went through it. But when you're heading for a cesarean section, you've got no idea. And so this has been super useful to just talk about everything from the anesthetics through to what happens to your baby immediately afterwards.

Meg: And then of course, a little bit on recovery. So. Tina, as always, thank you so much for your wisdom. It has [00:34:00] been fabulous connecting with you and yeah, we'll definitely be taking this conversation further with you another time. So thank you, Tina.

Tina: Thank you so much Meg. It was my pleasure.